STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445098	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, KNOXVILLE	809 EAST EMERALD AVE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on August 4, 2014 at 9:30 a.m. confirmed the corridor door to resident room 275 failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on	K 018	This Plan of Correction is submitted as required under State and Federal Law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity of regarding any of the deficiencies cited are correctly applied. K18 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department repaired the door to latch appropriately. 4 The latched doors will be inspected on a rotational basis to insure that the doors latch properly. The results of these inspections will be reported at the monthly safety meeting when there has been an issue.	8/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

BRAD SINFORD — ADMINISTRATOR — 8/28/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 29 2014

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K 018	Continued From page 1 August 4, 2014.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure stairwell doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on August 4, 2014 at 9:30 a.m. confirmed the stairwell door by room 317 failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the	K 021	K21 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department repaired the door to latch properly. 4. The latched doors will be inspected on a rotational basis to insure that the doors latch properly. The results of these inspections will be reported at the monthly safety meeting when there has been an issue.	8/8/14

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	445098	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2014**

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K 021	Continued From page 2 Administrator during the exit conference on August 4, 2014.	K 021		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire barrier's one (1) hour fire rated construction is maintained. (NFPA 101, 8.2.3.2.4.2.) The findings include: Observation and interview with the Maintenance Director, on August 4, 2014 at 9:45 a.m. confirmed an unsealed penetration in the ceiling at the following locations: 1. Dialer closet by the Fire alarm control panel had 2 ceiling penetrations. 2. Kitchen dishwashing area had a 12-inch opening in the corner and copper piping penetrating the ceiling. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 025	K25 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department repaired the penetrations by the fire control box and dietary department. 4. The maintenance department will inspect work by outside contractors prior to job completion to insure no penetrations exist, or to be able to repair the penetration quickly. Any repairs that are required will be reported at the monthly safety meeting.	8/15/14

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K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure reliable exits were readily available. Findings include: Observation and interview on August 4, 2014 at 5:34 a.m. confirmed one side of the front entrance 15-second delayed egress door failed to open when tested. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 038	K38 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department repaired the delay egress door to un-latch properly at 15 seconds. 4. The latched doors will be inspected on a rotational basis to insure that the doors latch properly. The results of these inspections will be reported at the monthly safety meeting when there has been an issue.	8/7/14
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide exit signs to indicate the direction of egress when the direction was not obvious. Findings include: Observation and interview on August 4, 2014 at	K 047	K47 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department installed a luminescent exit sign on the door to the laundry because of the low ceiling height in front of the door. 4. The exit signs will be inspected monthly by the maintenance director. Any exit sign that need repair will be discussed at the monthly safety meeting.	8/22/14

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K 047	Continued From page 4 5:35 a.m. confirmed no exit signs were provided at the 1st floor horizontal exit doors by the laundry.(NFPA 7.10.1.2, 7.10.2, 19.2.10.1) This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 047		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and record review, it was determined the facility failed to ensure the sprinkler system was maintained (NFPA 25, Table 5.1.1.2) . The findings include: 1. Observation with the maintenance director, on August 4, 2014 at 5:50 a.m. confirmed the third floor dining room had 1 of 3 sprinkler heads missing an escutcheon plate. 2. Observation with the maintenance director, on August 4, 2014 at 9:50 a.m. confirmed the sprinkler head behind the dryers was heavily loaded with lint. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 062	K62 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department installed an eschusion plate on the sprinkler head in the dining room and cleaned the sprinkler in the laundry area. 4. The sprinkler heads in the laundry area will be inspected by the maintenance department during their inspections in the laundry area.	8/15/14
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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K 069	Continued From page 5 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure commercial cooking equipment drip tray was provided with a drip tray beneath their lower edge. The findings include: Observation and interview with the Maintenance Director in the kitchen, on August 4, 2014 at 11:45 a.m. confirmed the exhaust hood was not provided with a grease collection container (NFPA 96, 3-2.6). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 069	K69 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The maintenance department replaced the grease drip pan on the dietary hood. 4. The dietary department and maintenance department will insure the drip pan is in place at all times.	8/22/14
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridors in the means of egress were maintained clear of all obstructions (NFPA 101- 7.1.10.2.1.) The findings include: Observation and interview with the Maintenance Director, on August 4, 2014 at 12:05 p.m.	K 072	K72 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The administrator conducted in-services reviewing this deficiency and the importance of keeping the exits clear as much as possible. 4. The department heads will conduct random surveys of the exits throughout the day and report any findings at the monthly QA meeting. Additional training for staff will occur until 100% compliance with this requirement is met.	9/15/14

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K 072	Continued From page 6 confirmed the rear exit corridor had a scale in front of the exit doors and the laundry area corridor had linen carts, racks and other obstructions in the means of egress. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 072		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD Is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly secure medical gas cylinders when stored. The findings include: Observation on August 4, 2014 at 5:55 a.m. confirmed three oxygen cylinders were secured in the 3rd floor storage room by room 305 (NFPA 99, 8.3.1.11.2, NFPA 55-7.1.3.4) . This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on	K 076	K76 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3. The administrator conducted in-services reviewing this deficiency and the importance of keeping oxygen stored properly. 4. The department heads will conduct random surveys of the hallways throughout the day and report any findings at the monthly QA meeting. Additional training for staff will occur until 100% compliance with this requirement is met.	9/15/14

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K 076	Continued From page 7 August 4, 2014.	K 076		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined electrical panels had the required clear space in front of them (NFPA 70,110-16 (d)). The findings include: Observation and interview with the Maintenance Director, on August 4, 2014 at 6:35 a.m. confirmed 2 of 2 2nd floor biohazard storage rooms had trash receptacle directly in front of the electrical panel.(NFPA 70, 110-26 (a)). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 4, 2014.	K 147	K147 1. No Residents were affected by this deficient practice 2 All residents have to possibility of being affected by this practice. 3 The housekeeping department was trained to remove the garbage can from the biohazard room on a regular basis to prevent one from being stored in the room at all. 4. Random checks will be conducted by the Housekeeping supervisor and the findings will be reported at the monthly QA meeting until 100% compliance with this regulation occurs.	9/15/14